APPENDIX 3 MHTP Outcomes, Principles and Strategies

INTRODUCTION

Appendix 3 provides a summary of the outcomes, principles, and strategies as defined by the subcommittees and task groups.

Section 1 – Subcommittee Outcomes

The following information contains the list of outcomes defined by the subcommittees. The corresponding Federal Goal associated with the outcome is identified in the right hand column.

Criminal Justice Subcommittee	1. Decreased number of people with mental illness from entering into the criminal justice system.	5
	2. Increased access to mental health and substance abuse services for those within the criminal justice system.	5
	3. Decreased number of people with mental health illness re-entering the criminal justice system.	5
Co-Occurring Disorders Subcommittee	1. Consumers will have access to appropriate, quality treatment regardless of barriers and/or resources. – Services will be specific to the individual's needs – There will be access to sufficient treatment providers who trained and retained.	4
	2. Affected parties are informed, educated and knowledgeable about co-occurring disorders and their recovery culture, principles and philosophy. – Peer-to-peer support is available to all who want it. – Communication between and among the parties is critical to making this successful. – Law enforcement officers receive crisis intervention training to deal with co-occurring disorders	4
	3. Increased system collaboration and service integration is prevalent across all allied systems and services. – Reduction in silos across system boundaries – Increased holistic services – Increased cross-system treatment	4
	4. Service Delivery is consumer driven and recovery focused. – There are options available outside of the current standard options such as homeopathic services.	2

Children, Youth, Parents And Family Subcommittee

1. Greater availability of State-Only Funds 5

   This would require a decrease in requirements around State-only funds and an increase in the flexible use of these funds. With that in place we would purchase with:

   - State-only Funds for parent organizations, mentorships
   - State-only Funds to serve those who are not in the country legally, non-Medicaid children/youth and families.
   - State-only Funds to serve working poor and people who have exhausted their insurance benefits

2. Youth and Family Support (this includes any caregiver family including foster, adoptive and kinship families) 2

   Increased parent and youth organizations, support groups, peer support and parent partners. Partnership involvement needs to be visible at all levels where youth and parents are always at the table; this includes parent/youth participation in client driven/directed services.

3. Training and Education 4

   This is inclusive of partnerships between professionals and parents/youth, cultural competence, which goes beyond linguistics and ethnicity, and professionals.

   - Trainings would include a basic level of information regarding mental illness and strategies and interventions about how to deal with issues as they surface.
   - Trainings would be targeted towards teachers, in an effort to help stabilize children and youth experiencing mental illness in the school environment. Trainings for parents, kinship caregivers, adoptive parents and foster parents would include behavioral intervention and crisis management skills. Other professionals also need to be trained and all trainings need to start early and include Birth to 3 issues.

4. A system that is more proactive than reactive 4

   Serve the WHOLE family with a full continuum of community based services, starting with prevention and early intervention. The continuum would include respite, wraparound services, day treatment, and evidenced based programs. It would build on family strengths and resiliencies and support parent partnering, and is well coordinated (seamless) among the systems. Services

	would be available to be delivered in the family home or other community location of family preference. • Revisit the Access to Care Standards and open the door to access.	
Youth In Transition Subcommittee	1. Consumers and family members have choices, utilize self-directed care and are sponsors, mentors and guides (i.e. peer-to-peer support). Services and supports are tailored to their cultural, community and individual needs.	2
	2. a) Seamless, holistic care to include mental health, physical health and dental integrated for all youth 13 – 24 that provides for access on demand and includes early identification, intervention, housing, benefits and transition to adulthood. Systems use practices that have been known to work.	4
	b) Reduce stigma through on-going education and training about recovery and resiliency developed by consumers and family members.	1
	3. Consistent access to quality services and supports available regardless of location or funding sources.	5
	4. Continual quality improvement is an integral part of all systems based on feedback and involvement from youth consumers and family members.	4
Adult Consumers And Families Subcommittee	1. Funding is attached to the consumer, allowing the consumer, with the assistance of a recovery coach, to select and self-direct services they believe will assist them in their recovery process and to purchase these services directly. All consumers will have a choice of services in which they can become engaged that include at a minimum: – Consumer-run services of various types – Individual therapy with a qualified therapist – Clubhouse services – Case management services	2
	2. State regulations will be modified to allow consumer-run entities that are independent of the community mental health agencies to provide Medicaid-eligible consumer-run services. – Within five years, these services will represent 25% of all mental health services in Washington State, and – Within five years, 20% of adult consumers are	2

	employed as service providers in traditional mental health agencies and/or in the new consumer-run entities.	
	3. Everyone working in the mental health system is trained and certified in psychiatric rehabilitation through college programs specially designed to provide such training. All recipients of services are also trained in psychiatric rehabilitation.	5
	4. The ombuds system is independent of the mental health system (MHD, RSNs, and provider agencies).	5
	5. Consumers have access to evidence-based vocational rehabilitation services on demand that include high quality supported employment based on national standards. These programs work collaboratively with DVR to ensure employment for as many consumers as possible.	8
Older Adult Consumers Subcommittee	1. Older Adults will have improved and consistent access to appropriate mental health services, including outreach to place of residence.	4
	2. Mental Health services for Older Adults will be provided and funded in an integrated holistic model of care including mental health, medical, substance abuse, social services and spiritual.	5
	3. There will be an increased number of service-providing individuals with professional expertise in mental health and aging.	5
	4. Appropriate mental health services for older adults are coordinated across all systems of care at state, regional and local levels.	4
Homelessness Subcommittee	1. Housing will be available immediately upon need for individuals/families.	5
	2. Services are available immediately, regardless of the financial or categorical status of the individual or family, while other benefits and services are being applied for.	5
	3. Continuation of services after a person has passed the crisis or transitional point (to avoid services and/or housing ending after a person is stable, decompensating back into homelessness).	5

Section 2 – Task Group Principles

The following tables contain the list of principles defined by the Task Groups.

Fiscal System Task Group Principles

The TWG approved the approach proposed by the Fiscal Systems Task Group to defer detailed fiscal systems strategies and adopt the principles defined by the task group to help determine detailed strategies in Year 2 when more information is known. The Task Group defined seven principles to guide their work in Year 2.

Financing strategies require a comprehensive and integrated approach

1. Seek to reduce funding silos and increase/expand integration of funding streams, within behavioral health programs and resources as well as across systems. Seek waivers to expand integration.
   - Possible strategy is to consolidate or blend behavioral health funds into one funding stream.
     - For example blend Healthy Options behavioral health benefit and RSN Medicaid benefit. Create one Medicaid behavioral health benefit; could be either carve-in or carve-out model.
     - For example combine all funding for community hospitals, state hospitals and long-term care with community based services into single funding stream.
   - Possible strategy is to establish integrated networks across funding streams and have single contracting mechanism with providers.
2. Behavioral Health funding is a scarce resource. Every effort to maximize third party liabilities (Medicare, private insurance, etc) as well as other sources of funding (grants, matching funds, alternative resources) should be made.
   - Possible strategy is, similar to Healthy Options Plans, provide RSNs an eligibility file with other member coverage identified. Require RSNs to implement coordination of benefit procedures for claims payment.
3. Service equality should be reflected in the distribution of resources and the reimbursement for services across the state. There should be a consistent array of services across regions and populations.
   - Possible Strategy is to adopt statewide funding rates that apply to all regions. This has been a major political issue in this state for several years. There has not been a satisfactory solution proposed.
   - Possible strategy is to adopt statewide maximum provider reimbursement rates by procedure code.
   - Possible strategy is to adopt and fund a basic benefit design available to all members and establish minimum service array

requirements.

4. Expand availability of early intervention and assessment for all populations.
    - Possible strategy is to drop or revise Access to Care standards for Medicaid members and require/establish that all members have same basic benefit, which includes at least an assessment/evaluation.
5. Reimbursement should be outcome based with incentives for adopting evidence-based practices.
    - Possible strategy is to adopt a process by which the state can approve alternative treatments, non-traditional service models and service innovations that are in addition to basic benefit. Some states call these value-add services. Should be cost neutral to the state.
    - Possible strategy is to adopt recovery and resilience based outcome measures for the system.
6. Consumers and families should have greater responsibility/opportunity to direct services and expenditures.
    - Possible strategies are Self-Directed Care Models and Money Follows the Person Program.
    - The Centers for Medicare and Medicaid Management (CMS) has issued a request for proposal for Self-Directed Care Programs as well as working on a Money Follows the Person Program. The state should pursue these programs and funding.
7. Efforts should be undertaken to reduce or simplify administrative burden for all components of system.

In addition to approving the above principles, the TWG directed the Task Group to ensure it addresses the importance of funding stability in its financing plan. Further, the TWG recommended to the Task Group that they expand the membership to include representation from other organizations as well, such as the Office of the Superintendent of Public Instruction (OSPI), the Department of Community, Trade and Economic Development (CTED), and the Employment Security Department (ESD).

Fiscal Systems Task Group Next Steps

The Fiscal Systems Task Group will be developing their financing plan over the next few months, in time for agencies to submit decision packages for priority budget changes to Washington's Legislature for the 2007-2009 biennial budget cycle. Upcoming activities will include:

- An assessment of current funding strategies.
- A review and documentation of best practices and "pockets of success."

- An exploration of Consumer Driven Service Models.
- An exploration of Integration Initiatives:
  - Behavioral/Mental Health and Physical Health;
  - Substance Abuse/Chemical Dependency and Mental Health; and
  - Encourage better coordination of services e.g., criminal justice/MH; schools/MH; Long-term care/MH.
- A feasibility study of Home and Community-Based Waivers.
- An exploration of opportunities to increase flexibility and choice of services.
- An assessment of ways to potentially decrease costs:
  - Explore unified paperwork, administrative outcomes; and
  - Improved benefit coordination.

Cultural Competence will be braided into all Transformation Activities

The TWG accepted several detailed strategies put forth by the Cultural Competence Task Group and recognized the need for a broader discussion of effective approaches to achieving greater levels of cultural competence in Washington's mental health system. The Cultural Competence Task Group identified guiding principles it will use to improve current competency levels and attitudes.

- Consumers, families and youth are members of the group that establishes the social marketing plan, providing guidance about plan feasibility for various communities.
- Consumers, families and youth will contribute to the development of intake and assessment procedures by being part of the workgroups charged with the development of the instruments.
- Consumers, families and youth will contribute by becoming part of the treatment team planning.
- Consumers, families and youth will contribute to the establishment of standards, accountability measures and financial incentive provisions.
- Consumers, families and youth will participate in curriculum development and act as consultants during the implementation process.
- Consumers, family and youth will participate as speakers in cultural competency trainings and help with curriculum design.
- Consumers, family and youth will participate by being part of hiring panels and committees that actively help recruit from their communities.

The task group will continue during Year 2 to refine the existing strategies, and develop new strategies that seek to infuse cultural competence

throughout the systems that provide mental health services.

Evidence-Based/ Promising/Emerging Practices

The Evidence-Based/Promising/Emerging Practices (EBPEP) Task Group members included a diverse mix of individuals comprised of consumers, advocates, clinicians, administrators, and researchers all committed to transformation of the mental health system of Washington State. Informed by the evolution of the concept of evidence-based practice in the scientific literature and the philosophy developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) the types of strategies included 1) evidence based, 2) promising, 3) emerging practices and 4) system strategies.

Necessary Elements for the Successful Implementation of Training

There are a variety of steps necessary to ensure the successful implementation of training into a new program or treatment practice. Past typical methods have been to offer training and then expect the staff trained in the new methods to go forth and implement. Rarely is this successful. Because of competing demands and expectations, new programs may not be a priority for everyone in the organization. Often, good intentions and verbal support may not be accompanied by practical support. Frequently, line staff, supervisors, and administrative staff are not fully aware nor do they appreciate the extra work required to handle a new program. As well, the sustainability of any new practice or treatment method takes continued support and encouragement over time to integrate the new, required skills and tasks into the operations of the organization. The following briefly outlines what is required for successful implementation.

Begin with Administrative Staff

Top administrative and supervisory support is critical. This is especially true when there are staff role changes, increased demands on time, the need for internal referrals or when supplies and equipment need to be purchased. Educating and obtaining support from key people in the organization greatly helps in the implementation of the project. Therefore, begin by meeting with administrative staff and mid-management staff to elicit their support in the new program. Provide them with information supported by data regarding what the costs and benefits will be to the clients and the organization. Provide an overview of the program goals and outcomes. Define the amounts of time for training and supervision that will be required. Define the general costs financially to the organization as well as emphasizing the possible gains.

Training Opportunities

It is best to create collaboration between mid-management staff and line staff when considering who in the organization will be trained to implement a new program. The collaboration assists an open communication related to the changes in staff responsibilities and roles as well as what resources may be necessary to ensure that line staff has the time to commit to the new program. Current staff skills and abilities need to be considered as well as how the new skills may enhance their competence. These issues need to be delineated prior to any training to diminish potential confusion and frustration. Training should be done in a

time sensitive manner in which the logistics of implementation have been defined and organized so that shortly after the training is completed, the program is actually implemented. Training tends to be most successful when it is skill specific, offering as much "hands on" and practice opportunities to the participants to demonstrate the skills needed. Supporting materials and readings that can be accomplished by staff prior to the formal training also enhances their readiness to learn.

Supervision and Follow-up

Implementation of a new program is more successful when training is followed up with supervision from expert staff that has experience with the program. Supervision should focus on assisting staff in skill acquisition by providing specific recommendations in behavioral terms. The use of video can be a very helpful tool in teaching new skills. Follow-up in the form of "booster" trainings to reinforce learning has also been helpful to anchor the new learning for staff. The sustainability of most new programs is increased with supervisory support of at least 6-9 months.

Consumer and Family Member Feedback

The above is predicated on the idea that a program will not receive training for a strategy or practice that does not resonate with consumer and family values. We believe it is important to actively solicit consumer and family feedback once a new program is running in order to make sure it continues to resonate with their needs and expectations.

Quality Assurance Methods and Approaches

Quality Assurance is a set of methods adopted to insure the highest quality of service delivery across a variety of disciplines, from business to medicine to mental health. In general, it focuses on improving both the process of delivering the service and the outcome of that service delivery.

In mental health, there has been much focus on improving process, especially for the delivery of psychosocial treatments. This has been accomplished by focusing first on training practitioners to deliver a given service competently. This requires specific nuts and bolts training in all the aspects of a treatment. Competence might be assessed by tape-recording or observing actual delivery of the treatment and assessing whether specific components or aspects of it were covered. Next, adherence/fidelity to the treatment over time would be assessed by periodic monitoring to assure that the treatment is being adhered to faithfully. There is a range of comprehensiveness in how meticulously competence and adherence are monitored, with procedures for research studies being far more detailed than procedures for routine clinical care.

A neglected part of quality assurance has been that of outcome. It has been shown that, if outcome is sequentially monitored over time and results are immediately fed back to those delivering treatment, that ongoing process monitoring is unnecessary once training is completed and initial competence is assessed and thought to be satisfactory. This innovative and more importantly easy to implement suggestion should be strongly considered. It only requires a carefully specified outcome or set of outcomes, and a method of easily measuring them over time.

Proposed System Outcomes Measurements

The task group encourages data collection methods that will further the effort to identify practices that are most effective in achieving consumer recovery. This data shall then be utilized to guide system-wide continuous quality improvement. The ultimate goal is to promote those programs and practices that are backed by evidence to be those that are most efficient and efficacious in achieving consumer recovery. To the extent that not all programs work as originally conceived and implemented, it is important to evaluate the actual outcomes of programs so that ineffective programs can be reconsidered and limited resources can be most effectively used. To achieve this goal, the transformation grant EBPEP subcommittee proposes a number of outcomes principles:

Principle #1

The Transformed Mental Health system shall emphasize outcomes data collection that identifies programs and practices that are most efficient and efficacious in achieving recovery for consumers who reside in our communities, including identified subpopulations

Principle #2

Outcomes data collection shall emphasize naturalistic data collection, be trended over time, analyzed with appropriate statistical methods, and compared against realistic and achievable benchmarks. Outcomes shall avoid "status quo" styles of benchmarking such as community standard and previous performance comparisons – and rather emphasize what is possible and achievable.

Principle #3

Outcomes data collection shall emphasize HOLISTIC assessments of service outcomes, including but not necessarily limited to:

- Symptom reduction,
- Family and social role improvement,
- Vocational educational function,
- Reduction in homelessness,
- Increase in independence,
- Decrease in criminal/justice involvement,
- Reduction of voluntary and involuntary hospitalization, and
- Subjective quality of life measures.

Criteria for Selecting Evidence-Based Practices

The following criteria are suggested as starting points in considering adoption of any given practice:

- Level of scientific support,
- Degree of patient centered choice recovery,
- Costs and costs effectiveness,
- Feasibility of the intervention,
- Availability of funding, and
- Ability to monitor and evaluate the effectiveness of the interventions.

Section 3 – Task Group Strategies

The following information contains the list of strategies defined by the Task Groups. The corresponding Federal Goal associated with the strategy is identified in the right hand column.

Fiscal Systems Task Group	1.	Seek to reduce funding silos and increase/expand integration of funding streams, within behavioral health programs and resources as well as across systems. Seek waivers to expand integration.	Goal Intro, 5
	2.	Behavioral Health funding is a scarce resource. Every effort to maximize third party liabilities (Medicare, private insurance, etc) as well as other sources of funding (grants, matching funds, alternative resources) should be made.	Goal Intro
	3.	Service equality should be reflected in the distribution of resources and the reimbursement for services across state. Should be a consistent array of services across regions and populations.	Goal Intro, 3
	4.	Expand availability of early intervention and assessment for all populations.	Goal Intro, 4
	5.	Reimbursement should be outcome based with incentives for adopting evidence-based practices.	Goal Intro, 5
	6.	Consumers and families should have greater responsibility/opportunity to direct services and expenditures.	Goal Intro, 2
	7.	Efforts should be undertaken to reduce or simplify administrative burden for all components of system.	Goal Intro
Cultural Competence Task Group Strategy	1.	Require participation of all mental health employees in an initial and ongoing annual training in cultural	3
	2.	Recruit and hire employees and leaders that reflect the population they are responsible to serve.	3
	3.	Develop and implement a training curriculum for cultural competency in collaboration with institutions of higher education, in particular Schools of Social work and psychology, Public Health, Medicine and Law in order for students and agency personnel to become certified as specialists and future trainers.	3
	4.	Revise WAC or MHD-RSN contract terms to afford opportunities for MH Specialists to be available to contracting agencies.	3

	5. Create roundtables to discuss and review cultural competency issues routinely with RSNs, Tribes, mental health providers, and state agency personnel	3
	6. Provide technical assistance and support to mainstream and specialty MH provider agencies to promote increased capacity to serve special populations, resulting in development of CC teams that will provide ongoing TA.	2, 3
	7. Identify, document, validate implement, and support promising programs and practices that currently exist in the community.	2, 3, 5
	8. Identify, implement, validate and support traditional medicines, alternative medicines and cultural traditional approaches that currently exist in the community.	2
	9. Support efforts to document and validate emerging programs and practices and disseminate promising programs and practices statewide	2, 5
	10. Provide financial and other incentives for achievement of cultural competence as demonstrated through comparable access and results from service across diverse population groups.	3
	11. Require outreach workers for diverse communities and cultural competence Specialists to become a part of the treatment team planning.	3
	12. Provide social marketing methods as a means to promote and increase cultural competence awareness.	1, 3
	13. Promote the development of linguistically and culturally specific intake and assessment procedures.	3
	14. Provide certified interpreters for deaf/hard of hearing and for limited to non-speaking consumers and family members that are qualified in mental health settings. Done in compliance and alignment with appropriate federal and/or state laws. Provide mental health,	3
	15. Develop Cultural and Linguistic standards and accountability measures.	3
	16. State and local government service agencies and their contractors and Tribes will be responsible for the achievement of Cultural/Linguistic standards and accountability measures.	3
Evidence-Based/Promising/ Emerging Practices	1. EBPEP 1a. Identify early childhood aggression and implement evidence-based practices around responding to early childhood aggression and conduct problems (e.g.,	5

	the Incredible Years program)	
2.	EBPEP 1b. Work with the schools to increase early identification of emerging aggression, conduct problems, and delinquency and implement evidence-based interventions (e.g., MST, FFT; see Appendix A for examples)	5
3.	EBPEP 1c. Establish treatment courts and court-based-interventions for youth and parents/caregivers with MH or SA disorders resulting in child abuse or neglect. (e.g. Family Treatment/ Dependency Court, or the Miami-Dade Infant Mental Health Court)	5
4.	EBPEP 1d. Establish treatment courts and court-based interventions for adult offenders with mental illness.	5
5.	EBPEP 1e. Jointly Establish procedures and policies for identifying youth who are appropriate for diversion	5
6.	EBPEP 1f. Institute and evaluate diversion mechanisms at every key decision-making point within the JJ continuum (see attachment for sample programs)	5
7.	EBPEP 1g. Provide Crisis Intervention Training to Police Officers	5
8.	EBPEP 2a. Develop mechanism for supporting relationship development maintenance between incarcerated parents and their children (e.g., TAMAR's children model)	5
9.	EBPEP 2b. Adopt a comprehensive collaborative MH-juvenile justice strategy for intervening at critical points in juvenile justice processing (initial contact, intake, detention, judicial processing, placement, probation, aftercare)	5
10.	EBPEP 2c. Perform MH screening and assessment routinely as youths move from point to point in the JJ system.	5
11.	EBPEP 2d. Provide evidence-based treatment models while within the JJ system (see Appendix B for sample programs)	5
12.	EBPEP 3a. Arrange for continued access to evidence-based care upon release including models such as Multi Systemic Therapy, Functional Family Therapy, and Family Integrated Transitions. (See attachment A for model aftercare programs).	5
13.	EBPEP 4a. Utilize models incorporating aspects of	4

cognitive behavioral therapy and Motivational Enhancement Therapy for integrated treatment for co-occurring mental health and substance abuse disorders.	
14. EBPEP 4b. Utilize contingency management strategies to support recovery.	4
15. EBPEP 4c. Utilize integrated group therapy.	4
16. EBPEP 5a. Treatment for parents in particular should incorporate trauma treatment into substance treatment approaches.	4,5
17. EBPEP 5b. Screening and treatment should deliberately inquire into if clients are parenting and how these challenges impact their parenting and family relationships.	5
18. EBPEP 5c. Implement Crisis Intervention Team (CIT) model for law enforcement officials	4
19. EBPEP 5d. Use peer support models such as dual recovery, double trouble.	2, 4
20. EBPEP 6a. Integrate systematic screening for mental health and substance use.	4
21. EBPEP 6b. Co-treatment oriented courts (such as Family Treatment Court, Drug Court, Mental Health Court)	4
22. EBPEP 8a. Mobilize Youth Empowerment and Engagement curricula (examples MOVE, TARGET-T)	2
23. EBPEP 8b. Identify and mobilize mentors, navigators, peer advocates and other supports for family members, youth and young adults	2
24. EBPEP 8c. Wraparound (specified model with quality monitoring)	5
25. EBPEP 8d. Consistent statewide mechanism to ensure that the philosophy/value of family and youth involvement is taught in certification, university, and other training programs	2
26. EBPEP 8e. Develop a mechanism to ensure funds are available to support family and youth participation in the planning, implementation, evaluation, and policy of programs and practices (i.e., stipends, transportation, childcare, etc.)	2,5
27. EBPEP 9a. Use Life skills development curricula that includes mental health education component (examples include MOVE, TARGET-T)	5

28. EBPEP 9b. Use navigators and peer advocates 5
29. EBPEP 9c. Integrate centers for health, mental health and life skills support (example school health clinics) 1, 5
30. EBPEP 9d. Use Transition centers 5
31. EBPEP 9e. Address needs of parenting youth – example Nurse-Family Partnership for all parenting youth or Young Parents Project in Miami-Dade 5
32. EBPEP 9f. Use Empowerment and Engagement curricula (examples MOVE, TARGET-T) 2, 5
33. EBPEP 9g. Use social marketing campaigns aimed at reducing stigma (example - Speak Up When You're Down is a social marketing campaign around normalizing PPD responses and reducing stigma already funded by the WA State Legislature) 1
34. EBPEP: 10a. Develop institutionalized consumer advisory boards. 5
35. EBPEP 11a. Develop institutionalized consumer advisory boards. 5
36. EBPEP 12a. MHD will pilot 2 Self-Directed Care Programs, one in Eastern Washington and one in Western Washington, based on the Florida SDC Model (please see above narrative for #12 regarding specifics of SDC model). 5

    - Consumers in this program will be paired with a trained life coach who will act as a brokerage support to assist in the overall design and management of their self-directed care plans
    - Consumers in this program will be eligible to purchase services for the purpose of accessing:
    - Clinical Recovery Services
        - Psychological Assessment
        - Medical Services(Psychiatric Evaluation, Medication Management)
        - PACT
        - Individual and Group Therapy provided by a licensed mental health professional
        - Supported Employment
    - Recovery Support Services(services that are alternative to traditional mental health services) such as:
        - Massage Therapy as a form of touch therapy to assist an individual overcome issues

documented by a licensed mental health professional
- Forms of Art Therapy
- Smoking cessation activities Occupational, speech, and physical therapy when recommended by a licensed mental health professional
- Services related to developing employability and/or productivity that will lead to employability

- Recovery Enhancements (tangible items for consumption that relate to employment or other productivity such as volunteer work or training/education)
  - Transportation
  - Non-cosmetic dental work
  - Hearing Aids
  - Non-cosmetic eye glasses and non-disposable contacts
  - Hair Cuts from a professional
  - Facial cosmetic and make-up products for the purposes of camouflaging medical conditions, such as facial scars, burns, etc., and for the purposes of seeking or participating in employment and/or other meaningful activities
  - Tutoring
  - Face-to face and distance learning educational classes
  - The initial costs of pet ownership(a maintenance plan must be submitted with action plan that details the ability to have the pet in the current place of residence, food and health upkeep, and care for the animal in the event of the individual's absence
  - Time-limited assistance to secure or maintain a more independent living arrangement(a maintenance plan must be submitted with action plan that details long-term financial ability to maintain the living arrangement)
  - Time-limited assistance with vehicle repair for purposes of employment and/or transportation to access Clinical Recovery Services
  - Entertainment items(i.e., movie tickets) and restaurant dinners if recommended by a licensed mental health professional

- Consumers will be provided comprehensive informational supports about medication assistance, treatment options, and potential providers.
- Consumers will be required to complete their own L Analysis, which takes the place of a professional generated Treatment Plan. The Life Analysis identifies recovery goals, and what is needed to accomplish those goals.
- Consumers will be encouraged to complete an Advance Directive; Relapse Prevention Plan; Crisis Plan; Personal Safety Plan; and Post Crisis Plan. The goal is for participants to take control of their own lives, and not be controlled by their illness, circumstances, or others.

37. EBPEP 13a. Fund the development of a minimum of one independent Consumer-run Drop-In/Resource Center in each RSN 2

    - These resource centers will serve as each area's umbrella organization, where trained peer counselors will assist individuals in the recovery process, including goal setting, warmlines, developing mutual self-help groups, teaching problem-solving skills, providing vocational assistance, and developing plans for symptom management using the Wellness Recovery Action Plan (WRAP) model.

38. EBPEP 13b. Fund the development of a minimum of two Recovery Education Centers, to be run by consumers, one in Eastern Washington and one in Western Washington. 2

    - These centers will serve as the state's technical assistance centers offering TA around consumer run services; principles of recovery.

39. EBPEP 13c. Fund the development of a minimum of one Clubhouse Model psychiatric rehabilitation program in each RSN based on the Fountain House Model. 2

    - Free-standing Clubhouse programs should be allowed to become one version of a "consumer-run entity."
    - The definition of a clubhouse should be the definition of a clubhouse program as articulated by the International Center for Clubhouse Development (ICCD).

- Clubhouse programs in the State of Washington should be required to be certified by the ICCD.
- Clubhouses should be funded in such a manner that makes it possible for the program to operate in complete fidelity to an ICCD defined clubhouse.
- Clubhouse funding must be flexible enough to ensure that clubhouse services are consumer-directed, and that the clubhouse's overarching focus is vocational rehabilitation and job and educational placement.
- Clubhouses are not clinical programs – admission criteria and service planning is not based on diagnosis, level of functioning or medical necessity. Clubhouses are adjunctive to clinical services and focus on people's strengths.

40. EBPEP 13d. Expand Personal Assistance Services (PAS) for people with psychiatric disabilities. PAS is a method which already has a long and successful track record for serving people with disabilities in a self-determined manner, and for which Medicaid funding is already available.	2
41. EBPEP 14a. Use 4 year and 2 year colleges to train professionals and para-professionals in psychiatric rehabilitation.	5
42. EBPEP 14b. Encourage reinstatement of psychiatric rehabilitation programs at WSU and in the EWU Social Work departments and in additional undergraduate schools	5
43. EBPEP 14c. Develop certificate and AA programs at community colleges in alignment with USPRA program requirements	5
44. EBPEP 14d. Establish a Recovery Education Center School which would be licensed by the State of Washington degree in behavioral health recovery	5
45. EBPEP 14e. Establish Recovery Schools as a post-secondary educational institution.	5
46. EBPEP 16a. Use Individual placement and support (IPS)	4, 8
47. EBPEP 16b. Use Assertive community treatment with employment component (ACT)	8
48. EBPEP 16c Provide supported employment (SE) and Clubhouse-based Transitional Employment (TE).	8

49. EBPEP 16d. Use peer support (PS), WRAP, Club House, and supported education as a way to maintain recovery and retain employment.	8
50. EBPEP 16e. Provide support for consumer-owned and operated businesses	8
51. EBPEP 16f. Cross train VR staff and clinical and vocational mental health staff to increase integration and communication.	8
52. EBPEP 17a.Use Depression Care Management (e.g. IMPACT, PROSPECT)	5
53. EBPEP 17b. Implement Gatekeeper programs	4
54. EBPEP 17c. Use the Program to Encourage Active and Rewarding Lives for Seniors (PEARLS)	4
55. EBPEP 17d. Geriatric Regional Assessment Team (GRAT)	4
56. EBPEP 17e. Case Management	4
57. EBPEP 18a. Depression Care Management (e.g. IMPACT, PROSPECT)	5
58. EBPEP 18b. Include inquiry into provision of care giving to children.	5
59. EBPEP 19a. Continue Geriatric Mental Health Specialty Training	5
60. EBPEP 19b. Provide Co-occurring disorders training	5
61. EBPEP 20a. Elder Wrap Around	4
62. EBPEP 20b. Expanded Community Services (ECS)	4
63. EBPEP 21a. Programs are developed for youth and young adults that are developmentally appropriate and meet the unique, individualized needs of this population. Such models should include access to and availability of comprehensive support services including mental health, substance abuse, independent living skills, and vocational training are provided to assist youth and young adults in maintaining housing (Local examples –Youth Care Model, Mockingbird Family Model programs)	5, 7
64. EBPEP 21b. Establish Housing First: Large investment in development of enough permanent subsidized housing to meet the needs of all homeless people with mental illness. Appropriate supportive services need to be attached to housing.	5, 7

65. EBPEP 21c. Establish some transitional housing options to provide for overflow need.	5, 7
66. EBPEP 22a. Implement a consistent statewide approach to ensuring that family mental health supports are available for all family members (Birth on up) during both periods of homelessness and transition.	5
67. EBPEP 22b. Use Multi-disciplinary teams including mental health and chemical dependency specialists, RN/ARNP, case managers, and peer supports are available at drop in centers and shelters to provide assessment, services and supports	5
68. EBPEP 22c. Make available Medical Respite for youth and young adults	5
69. EBPEP 22d. Make needed mental health and general community support services immediately available to those requiring assistance in process of stabilizing while entitlements are pursued	5
70. EBPEP 22e. Implement PACT teams	5
71. EBPEP 22f. Establish a medication initiation and maintenance service that can be quickly and easily accessed by people without Medicaid or those with Medicaid who have not been able to get enrolled in community mental health services.	5
72. EBPEP 22g. Create an ample supply of outreach and engagement teams aimed at identifying, engaging and stabilizing homeless persons with mental disorders	5
73. EBPEP 24a. Undertake a comprehensive, cross-system financing strategy for child, youth, and family mental health that aims to maximize federal entitlements, increase flexibility, and fit state-only funds to state and local needs.	5
74. EBPEP 24b. Collaborate with Insurance Commissioner around options for ensuring EBTs are reimbursable through private insurance plans.	5
75. EBPEP 24c. Programs working effectively with immigrant families (regardless of legal status) with young children – See examples in Appendix D.	3
76. EBPEP 25a. Develop a state-wide Youth and Family Engagement Academy to mobilize funding, develop training, and match family and/or youth involvement models to community needs (See Appendix C for example family support models)	5

77. EBPEP 25b. Designate funding specifically to create/support/ maintain Family and Youth Organizations and support programs — 2

78. EBPEP 25c. Review statutory & administrative constraints to funding/reimbursement of parent/ youth partners and minimize barriers — 2

79. EBPEP 26a. Create a statewide Mental Health Technical Assistance, Training and Resource Center that is modeled off of the national technical assistance centers. — 4

80. EBPEP 26b. Ensure that a specific component of the statewide training and TA center is directed at education for Primary Health Care Providers (PHCP) — 4

81. EBPEP 26c. Implement a statewide approach to supporting school staff to help stabilize children and youth experiencing mental illness in the school environment. Specifically consider Positive Behavioral Interventions and Supports (PBIS). — 4, 5

82. EBPEP 27a. Create an Evidence-Consensus Based/Promising/Emerging Practice (EBPEP) Institute to provide mechanisms to — 5

    (A) oversight and direction toward the implementation of EBPs including consumers, parents, and youth;

    (B) review, monitor, and disseminate information on evidence-based practices and current research;

    (C) assisting communities to identify local needs, select evidence-based approaches and provide technical assistance for implementation; and

    (D) evaluate and maintain strategies including evaluating current and new practices and monitoring for fidelity, outcomes

83. EBPEP 27b. Ensure that promising family-centered processes and support services voiced as needs by communities that are not focal treatments (e.g., Youth and Family Supports/Parent Partners, including parent organizations, support organizations, peer support, parent partners, Mentoring, Respite Care services, the Wraparound process, Day treatment programs) are supported and included as options for communities — 2

84. EBPEP 27c. Restructure the Access to Care Standards to ensure treatment can easily be provided: — 4

    - in a non-clinic setting (home, childcare center)

- to caregiver-child dyads and other family constellations
- for disordered relationships even without a presenting primary diagnosis in the adult or child
- for caregivers with mild to moderate mental health challenges with a specific focus on mitigating the impact of their mental health challenges on parenting
- for children at-risk of developing severe emotional-behavioral disorders
- for children exposed to trauma or violence regardless of presenting diagnosis
- for drug-exposed infants and their caregivers regardless of presenting diagnosis

85. EBPEP 27d. Specifically address provision of appropriate infant, toddler and early childhood mental health services 4

    - Statewide adoption of the DC:0-3R for children Birth through 5 years of age.
    - B. Provision of appropriate relationship-based services when possible and appropriate (see Appendix C – 4 for examples).